

St. Catherine University

SOPHIA

Master of Social Work Clinical Research Papers

School of Social Work

5-2016

Barriers Trauma Presents Academically for Elementary School Students: What can schools do?

Autumn Terlouw

St. Catherine University, autumn.terlouw@gmail.com

Follow this and additional works at: https://sophia.stkate.edu/msw_papers



Part of the [Social Work Commons](#)

Recommended Citation

Terlouw, Autumn. (2016). Barriers Trauma Presents Academically for Elementary School Students: What can schools do?. Retrieved from Sophia, the St. Catherine University repository website:
https://sophia.stkate.edu/msw_papers/691

This Clinical research paper is brought to you for free and open access by the School of Social Work at SOPHIA. It has been accepted for inclusion in Master of Social Work Clinical Research Papers by an authorized administrator of SOPHIA. For more information, please contact amshaw@stkate.edu.

Barriers Trauma Presents Academically for Elementary School Students:
What can schools do?

by
Autumn J. Terlouw, B.A.

MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work
St. Catherine University and the University of St. Thomas
St. Paul, Minnesota
in Partial fulfillment of the Requirements for the Degree of
Master of Social Work

Committee Members
Courtney Wells, MPH, MSW, Ph.D.
Marisa Biolo, MSW, LICSW
Steven Banks, MSW, LICSW

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Table of Contents

Abstract	3
Acknowledgments	4
Introduction	5
Literature Review	7
Definition of Childhood Trauma	7
Common Diagnoses	8
Effects of Trauma on Children's Brains	9
Fear Response	10
Hypothalamus	10
Amygdala	11
Hippocampus	11
Fight, Flight, Freeze	12
Memory	13
Effects on Academics	14
Acting Out	14
Poor Academic Status	15
Drop Outs	15
Summary	16
Conceptual Framework	17
Developmental Repair	17
Ecological Perspective	19
Methods	21

Research Design	21
Sample	21
Protection of Human Subjects	22
Data Collection Instrument and Process	22
Data Analysis Plan	23
Findings	24
School Professionals' Backgrounds	24
Participant 1	24
Participant 2	25
Participant 3	26
Participant 4	26
Themes	27
Developmental Barriers	27
Strategies the School Uses	29
Discussion	37
Recommendations for Future Research	42
References	43
Appendices	48
Appendix A	48
Appendix B	49
Appendix C	51
Appendix D	52

Abstract

The purpose of this study was to gain a better understanding of what a specific elementary school in an inner-city school district of Minnesota is doing to breakdown the barriers trauma presents in children's academic achievements. Qualitative interviews were conducted with four school professionals who were asked to discuss how trauma affects students and what their school is doing to help students. Consistent with previous literature, participants identified developmental barriers as the largest impact on students as well as environmental factors. Additionally, the participants unanimously discussed feelings of inadequacy and the need for more trauma training as school professionals. This led to the recommendation that the school board and board of social work provide a minimum trauma education requirement before entering the education and social work fields.

Acknowledgements

I would first like to thank my committee chair, Courtney Wells for her constant dedication and support throughout the course of this research paper. I am grateful for the input and time and effort you put into helping me make a quality product. I really appreciate all the help you give me through this process.

I would also like to thank my committee members Marisa Biolo and Steven Banks. I appreciate taking time out of your busy schedules to provide your expertise during this process. Thank you for sharing your knowledge and experience with me, and for your continued commitment to working with children who have experienced trauma within our schools. It was an honor to work alongside both of you, and I cannot thank you enough for your help.

Finally, I would like to thank my family and friends for the support they gave me throughout this process. I especially want to thank my husband for being so patient with me while I was busy conducting my research and sacrificed time together. You truly are the biggest support in my life, and I am so thankful for your support!

Barriers Trauma Presents Academically for Elementary School Students: What can schools do?

Trauma is a universal experience that impacts individuals regardless of race, gender, and age, among many other things. While trauma is detrimental to all people, childhood trauma can have life-altering repercussions on children (Painter & Scannapieco, 2013). These repercussions affect children not only in their personal lives but also in their school lives. Many times children with social, emotional, and behavioral challenges are misunderstood. Parents do not know how to help their children and sometimes, teachers find themselves wearing too many hats and are unclear as to what their role is within the school. Each person is doing the best they can with the tools that they have, though it can be difficult to see that in each other (Greene, 2014).

With this information in mind, schools are working to better assist their students in any way possible. One way schools are doing this is in becoming trauma-informed. A trauma-informed school is one that provides an environment where there is shared understanding of the affects of trauma among all staff. The school needs support all children to feel safe physically, socially, emotionally, and academically, the school addresses students' needs in holistic ways. This can be done by taking into account relationships, self-regulation, academic competence, and physical and emotional well-being. The schools need to explicitly connect students to the school community and provide multiple opportunities to practice newly developing skills, the school embraces teamwork and staff share responsibility for all students, and the leadership and staff anticipate and adapt to the ever-changing needs of students (Trauma and Learning Policy Initiative, 2016). The school districts in Minnesota are working to provide trainings and information for schools, but there is limited information about where the districts are at in

producing trauma-informed schools.

The purpose of this study was to gain further understanding of what a specific elementary school is doing to help children who are impacted by trauma and the barriers they face in their education. For the purpose of this study there was a focus on mental health and school professionals who had experience working with children experiencing trauma at an elementary school in an inner-city school district in Minnesota. The study focused on children between the ages of four and twelve, as this is the age range of students in the elementary school. The school is in the process of becoming a trauma-informed school and has a large number of high needs children. This school adopts these six principles in being trauma-informed: always empower, never disempower, provide unconditional positive regard, maintain high expectations, check assumptions, observe, and question, be a relationship coach, and provide guided opportunities for helpful participation (Wolpow, Johnson, Hertel, & Kincaid, 2011). There are a wide variety of cultures, ethnicities, and socioeconomic backgrounds represented at this school, which will be discussed further in the methods section of this paper. A review of the literature will be provided, followed by the conceptual framework used to guide the research process. A qualitative, case study research method was utilized in interviewing four school professionals who have experience working with children experiencing trauma within the school.

Literature Review

Definition of Childhood Trauma

According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V), the following criteria are required for a diagnosis of post-traumatic stress disorder (PTSD): directly experiencing a traumatic event, witnessing in person a traumatic event as it happens to another person, learning that a traumatic event occurred to a close family member or close friend that was violent or accidental, or experiencing repeated or extreme exposure to aversive details of traumatic events (American Psychiatric Association, 2013, p. 271). While these qualifiers make up the diagnostic criteria for PTSD, this definition only allows for surface level insight into what an individual may experience in as traumatic. It has been argued that children are given a diagnosis due to situational symptoms, and the diagnosis does not reflect the reality of the child but simply pathologizes the child (Greene, 2014).

Trauma can come in many forms and not every traumatic experience is violent. The perception that something bad could happen alone can be a traumatic experience for some. A few examples of what children may experience as trauma include physical or verbal abuse, sexual abuse, witnessing drug or alcohol abuse, domestic violence, witnessing murder, immigration, community or school violence, being a part of or witnessing a vehicle accident. Many children will experience trauma and not develop trauma symptoms. It depends largely on the child's age and developmental level (Berliner, 2013; Cook et al., 2005; Spinazzola et al., 2013).

According to Walkley and Cox (2013), there are two ways to view how this type of stress may affect a child. On one side there is developmentally appropriate stress that

helps a child develop resiliency and coping skills. On the other hand there is traumatic stress that can leave a child feeling horrified and helpless. Briere (1992) makes this point about childhood trauma,

Like other victims, abused children experience significant psychological distress and dysfunction. Unlike adults, however, they are traumatized during the most critical period of their lives: when assumptions about self, others, and the world are being formed; when their relations to their own internal states are being established; and when coping and affiliative skills are first acquired (p. 17).

Children are a vulnerable population. It is clear that trauma has a significant effect on their future development and abilities to cope.

Common Diagnoses

While it is important to understand the general definition of trauma, it is also necessary to be educated on the most common trauma diagnoses in children. One of the most common diagnoses when dealing with trauma is PTSD as defined earlier (Cohen et al., 2006). Children may not always meet full criteria for a diagnosis of PTSD and this diagnosis does not necessarily capture the developmental impact trauma has on a child (Beehler, Birman, & Campbell, 2012; Cook et al., 2005; Kisiel et al., 2014; van der Kolk, 2005). There has been push for a new diagnosis for children. The suggested diagnosis is developmental trauma disorder (DTD) (Ford et al., 2013; Kisiel, 2014; van der Kolk, 2005).

The proposed diagnosis of developmental trauma disorder (DTD) is intended to offer a framework that could be used to more appropriately identify and treat children and adolescents with exposure to complex interpersonal trauma and

associated patterns of dysregulation across areas of development. The proposed criteria address (a) exposure to multiple or prolonged adverse events over the period of at least one year including both direct experience or witnessing of events and disruptions in protective caregiving, separation, or emotional abuse; and (b) complex traumatic reactions, including repeated patterns of dysregulation across multiple areas (Kisiel et al., 2014, p.3).

Other common diagnoses among children suffering from a history of trauma include attention deficit hyperactivity disorder (ADHD), depression, eating disorders, generalized anxiety disorder, oppositional defiant disorder (ODD), reactive attachment disorder (RAD), sleep disorders, and stress disorders (Briere, 1992; Briere & Scott, 2015; Cohen et al., 2006; Cook et al., 2005; van der Kolk, 2005).

Effects of Trauma on Children's Brains

Dr. Bruce Perry (2000), director of the Child Trauma Academy, explained: “When a child is threatened various neurophysiological and neuroendocrine responses are initiated. If they persist, there will be ‘use-dependent’ alterations in the key neural systems involved in the stress response” (p. 50). This shows that when a child goes through a traumatic experience, it does much more than meets the eye. Depending on when the trauma occurs, trauma has the ability to either affect the structure of the brain (infancy) or alter brain functioning (later childhood) (van der Kolk, 2003). Children are still at a point where their brains are developing because the brain develops until adulthood and trauma can alter the normal functioning brain.

Fear response.

To gain a better understanding of how trauma affects the brain in specific ways, one must look at the fear response in the brain. The limbic system is the area of the brain where emotions are regulated and memories are formed. This is found in an area of the brain called the cerebrum. The limbic system is made up of four key structures. For the purposes of this paper only three will be discussed: the hypothalamus, hippocampus, and amygdala (Painter & Scannapieco, 2013, p. 277).

Hypothalamus.

The general functioning of the hypothalamus is that it regulates the autonomic nervous system. This system controls blood pressure, heart rate, and states of arousal. When hyperarousal is discussed in trauma situations, it is a direct reflection of what is happening in the hypothalamus.

Hyperarousal occurs when children who are exposed to chronic, traumatic stress develop pathways in their brain for fear response and create memories that automatically trigger that response without conscious thought. These children have an altered baseline for arousal and will overreact to triggers other children find nonthreatening (Painter & Scannapieco, 2013, p. 278).

In an attempt to compensate for hyperarousal, people experiencing trauma tend to shut down on a behavioral level by avoiding stimuli of the trauma. Many people suffering from trauma tend to become devoid of feelings or emotions, this can also be described as dissociating (van der Kolk, 1994).

The hypothalamus also activates individuals' adrenaline, as well as the pituitary glands, which produce hormones necessary for actions to counter danger. This area of the

brain is intimately related to how the body responds to strong emotions and the survival mode. The hypothalamus also regulates anger and aggressive behavior (Painter & Scannapiecco, 2013; Rustin, 2012).

Amygdala.

The amygdala is located in the cerebral hemisphere of the brain. Though it is tiny it plays an imperative role in memories and motivation. These include emotions such as fear, anger, and pleasure. Research also shows that the emotional aspects of memory are stored in the amygdala, and it is known as the most sensitive structure of the brain. The amygdala plays a large role in emotional memory processing, interpreting, and integrating emotional functions (Painter & Scannapiecco, 2013; Rustin, 2012; van der Kolk, 1994). It is important to note that any damage to the amygdala will interfere with peoples' ability to detect facial expressions of fear (Rustin, 2012). This becomes a difficult task for individuals who experience trauma. A common symptom is that they cannot understand or detect how others are feeling or relate to others on an emotional level. This can put individuals who have damage to the amygdala in difficult situations because they become the one creating a fearful situation due to their inability to understand facial expressions.

Hippocampus.

Rustin (2012) explains the hippocampus as a structure that is important in coding and eliciting memories, as well as creating connections to specific emotional responses. While the hippocampus does not store memory itself, it does play a significant role in memory retrieval and subjective remembering. Rustin (2012) also explained that the hippocampus works to regulate the amygdala. Teicher et al. (2003) further discuss how

the hippocampus also plays a role in behaviors. Continual stress keeps neurons from developing and cause the figurative death of dendrites, which are where impulses are generated. As a result of these occurrences, memories and learning are affected negatively. This also affects an individual's ability to act behaviorally appropriate. This means that the hippocampus plays a large role in fear and trauma (Rustin, 2012).

Fight, Flight, or Freeze.

Fight, flight, freeze are somatic reactions to fear. When faced with a situation that induces fear a person will fight, run (flight), or freeze. Rustin (2012) gives a good explanation of what happens when a person freezes. When an individual is faced with a dangerous situation they may not have the capability to fight or flee. Therefore, the person remains frozen in a state of danger. The limbic system behaves as if threat is still present.

Fear response is largely responsible for the hypervigilant 'fight, flight, or freeze' state of many trauma-affected children. Children who are easily overstimulated have difficulty with emotional regulation, and they struggle to put feelings into words. Anger is often accompanied by physical aggression, and this is the most common response seen in children (Cross, 2012; Perry, 2006). Severe and persistent adversity in childhood can lead to impaired cognitive and physical development (Cook et al., 2005; Walkley & Cox, 2013).

Nadine Burke Harris gave a helpful example of what this looks like in a TED Talk she gave in September 2014. She described fight, flight, or freeze through the illustration of seeing something frightening. Imagine an individual sees something that induces fear. The hypothalamus then sends a signal to the pituitary, which sends a signal

to the adrenal gland that says, “release the stress hormones, adrenaline, and cortisol!” The heart then starts to pound. The individual is then ready to fight. She then asked the question: “what happens when that fear comes home with you every single night?” The system is adaptive or maladaptive. Children are sensitive to repeated stress activation because their brains are still developing.

Memory

Trauma can also have a large impact on children’s memories. Research shows that children who were abused had a higher risk of lower intelligence quotient (IQ) scores. These children were also identified as having a learning disability, performing academically below grade level or having difficulties concentrating (Armsworth & Holaday, 1993). Rustin (2012) also discusses how traumatic stress affects the functioning of the hippocampus, which as discussed earlier, means that memories can be compromised in the process.

Disassociation is also brought up many times when looking at memory in trauma experiences. Briere (1992) defines disassociation as, “a defensive disruption in the normally occurring connection among feelings, thoughts, behavior, and memories, consciously or unconsciously invoked in order to reduce psychological distress” (p.36). Many victims of trauma will disassociate as a way to protect themselves from the traumatic experienced. Generally this is an unconscious experience, so children are not aware that they are doing this. It presents as having no memory of the incident and events that happened around the trauma (C. Hollidge, personal communication, October 25, 2015).

Effects on Academics

Having a better understanding of how trauma affects children's brains allows for better understanding of academic difficulties that students face. One of the most difficult aspects of school for children suffering from trauma is that they do not feel safe and secure in the environment. While teachers can create a safe classroom, the moment students walk out of that room, the sense of safety is gone. In order to create an environment where students feel safe the whole school must adapt a safe environment (Bornstein, 2013).

Unfortunately, this is not a common practice among schools. Many students fall through the cracks because they are seen as "problem" children (Greene, 2014). Due to trauma, children will act out in many ways such as demonstrating irritability, aggression, anger, somatic complaints, hyperarousal, and attention (Koffman et al., 2009; Pinna & Gewirtz, 2013; Stein et al., 2003).

Acting out.

When children are behind in school, feeling less than their peers, struggling with internal issues they tend to act out. "Problems with processing include intrusive thoughts, repetition of behaviors related to trauma that cause harm to others or self, avoidance, hyperarousal, difficulties of attention and distractibility, and disorganization in attachment" (Porche, Fortuna, Lin, & Alegria, 2011, p. 983). Not only will children act out through attention difficulties and hyperarousal, other symptoms can present as well. Research shows that children who are exposed to violence can have significant behavioral problems, which present in their classrooms (Koffman et al., 2009; Stein et al., 2003).

Somatic (physical) symptoms are very common for children dealing with trauma. Some children do not have the language to express what is happening to them, so they will communicate through somatic symptoms. For some children this will mean frequent visits to the nurse, absences, and complaints of feeling ill or pain. According to the National Child Traumatic Stress Network (2015) students may report symptoms such as stomachaches, headaches, or different pains. There may also be notable behavioral changes, for example increased irritability or aggression.

Poor academic status.

Among the physical symptoms that are present in students suffering from trauma there are also academic struggles. The National Child Traumatic Stress Network (2015) states, “changes seen in students may affect IQ and ability to regulate emotions (p. 1).” Students are dealing with many difficult things in their lives, and these different symptoms can have an effect on their schoolwork and grades. Research also shows that trauma can lead to lower grade point averages, negative marks on cumulative records, and poor attendance rates (National Child Traumatic Stress Network, p. 1).

Drop Outs.

Many students fall through the crack, which leads to dropping out of school. There is a great volume of information that shows dropout rates linked to family and school factors, but there is a deficit of information regarding mental health or trauma factors in dropout rates (Porche et al., 2011).

There is very little research on mental health issues leading to dropouts, so there is no way to determine how many students have left due to their internal struggles. Dropping out of school is not a sudden event. It is a process that begins in students’ early

years. Students are influenced by many different stressors including sociodemographics, family stress, and parental and personal resources (Alexander, Entwisle, & Kabbani, 2001; Cohen, et al, 2006). These are the same factors seen in trauma victims.

Summary

In summary, the literature regarding childhood trauma is extensive in understanding how trauma affects the brain. It is clear that there is much more going on in a child who has been traumatized than most people think. There is a common view that children are resilient and can bounce back from situations quickly; when in reality children are not resilient, they are malleable (Perry, Pollard, Blakeley, Baker, & Vigilante, 1995). While there is an abundance of research examining the effects trauma has on the brain, research is lacking in how schools can help children who are experiencing trauma and how it affects their academics. This case study seeks to gain an understanding of the steps an elementary school in an inner-city school district in Minnesota is taking to help children who are experiencing trauma and what barriers these students face in their education.

Conceptual Framework

Throughout research, it is very apparent that the developmental process is essential in understanding trauma. For this reason, Ann Gearity's Developmental Repair Model will be one area of focus for the conceptual framework for this paper. The ecological perspective will also be a focus for this research as this perspective looks at the different influences and different levels in an individual's life.

Developmental Repair

Children's behaviors in the classroom are not straightforward. There are no black and white answers for why a child is struggling in school. Gearity (2009) has developed the developmental repair model to help understand the thinking and behaviors of children experiencing trauma, which Gearity describes as "children at risk." In *Developmental Repair: A Training Module* (2009), Gearity gives four domains for this model: relating, thinking, feeling, and acting.

The first domain, relating, also described as forming a co-regulating partnership, looks to the relationship between child and adult. While this model assumes the role of adult as parent, this role also applies to any adult figure in a child's life. Children who have experienced or are experiencing trauma most commonly have developed an expectation that adults are not a consistent source of care. This means that children expect adults to disappear, become overwhelmed, or be threatened in moments of distress. This model looks to help repair this relationship by helping children see adults as a "regulatory partner." This is a two-way street. Both the adult and child need to work at this relationship. It starts with the adults showing their intention to help. Adults need to be able to recognize a child's distress, tolerate it, and resist from seeing the behavior as

bad. Children on the other hand must become active partners in this relationship too. It is essential that they take the help (Gearity, 2009).

The second domain is thinking, also referred to as helping children use their minds. “Developmental repair actively works to repair reflective thinking and help children organize (make sense of) interpersonal expectations and associations” (Gearity, 2009, p. 44). At-risk children have missed out on relational experiences that help them make sense of situations, so many times they do not know how to think for themselves. This model works to help children learn how to reflect and organize their thinking. The main areas of focus are learning to reflect, supporting self-care/self-sense, developing self-awareness skills, and introducing problem-solving skills (Gearity, 2009).

The third domain is feeling, also known as regulating and using emotions. Emotions are responses sparked by stimulation. They allow anyone to understand their needs and help understand others’ reactions to shared experiences. This area looks to help children discover and regulate these feelings (Gearity, 2009). “As children know their emotions, they can better manage emotional distress and behavioral upset” (Gearity, 2009, p. 44).

The final domain is acting or using effort to manage behaviors. In this part of the model the idea of managing instead of fixing behaviors is discussed. The goal is to “actively help children become motivated to learn new patterns or new ways of functioning that increase internal behavior control and improve social inclusion” (Gearity, 2009, p. 44). At-risk children present with severe behavior/control problems and this is seen many times in the classrooms. This model takes a very realistic approach

on internal controls. The focus is that children should learn how to own their actions and understand the impact their actions have on themselves and others (Gearity, 2009).

Ecological Perspective

The ecological perspective describes the interactions between varying levels of systems that guide the way in which a clinician views the client's problem, and the interventions to be used. The problem does not lie strictly within the client, but in the interaction between client and their environment. This perspective is made up of three systems: micro, meso, and macro.

The first system, micro, includes all of the relationships that the individual has with their immediate environments (Rogers, 2006). These environments include places where the client has immediate contact on a daily basis. A few examples of micro-systems include home, work, school, and neighborhoods (Rogers, 2006). For a child, their main interactions occur with parents or caregivers, teachers, and other professionals. These are very close relationships that will affect the child on a personal level.

The meso-system includes the interactions between two or more environmental settings (Rogers, 2006). At the meso-level the environments that most children would be effected by would be school, communities in which they live, churches that they attend, etc. These are still personal connections, but they are more distant than the micro-level environment. Children are very much affected by issues at the meso-level. For example, conflicts at school (whether with a teacher or other student) can have a significant effect on a child. This can present in many ways, one of the more common presentations is behavioral issues at school or home.

The final level is macro-system. This consists of cultural factors such as values,

beliefs, and norms that affect the environments that a person lives in and, as a result, will affect the individual's development (Rogers, 2006). For example, in a child who is dealing with behavioral issues, the stigma that surrounds behavioral difficulties or mental health is a macro-level issue.

The Developmental Repair and Ecological Models add an important lens to the research. The ability to analyze data with the mindset of the developmental issues at hand and the different levels of which children are affected allow for a more well rounded approach in comparison to looking at the research from a one level approach. For example, looking at a child's behavior as the only problem at hand. The key point in both of these models is to approach a child knowing that there is a lot more going on in that child's life than one simple presenting problem.

Methods

Research Design

A qualitative research design was used for this case study. Interviews were conducted at an elementary school in the Twin Cities and were open to all staff. There were four staff that participated in the interviews. The questions were open-ended which allowed for the professionals to expand upon their answers. This elementary school has a very diverse population. The school has about 600 students, prekindergarten-fifth grade. Of those students, 97% qualify for free and reduced lunch, but the school provides free breakfast and lunch for the students due to the need. Sixty-four percent of the student population are English Language Learners (ELL) due to a large population of immigrant families. The demographic breakdown of the school is: American Indian 1%, Asian 53%, Hispanic 8%, African American 35%, and White 3% (Personal Communication, March 25, 2016). This elementary school was chosen for this case study due to their adoption of a trauma-informed environment. This is not the norm for many schools in the Twin Cities, and this elementary school works closely with families and children to address symptoms of trauma. This school has three social workers, behavioral intervention specialists, para-professionals, administration and works with mental health agencies to best aid in students' education and well-being.

Sample

A letter (see Appendix C) was sent to the school as an invitation to participate in this case study. The researcher received a signed consent form from the school to be able to conduct the study. Due to the school's consent this meant that the school was in support of the research and they distributed study information via flyers and emails to

staff (see Appendix D). The school provided a private space to conduct the research, while participants also had the option to meet outside of school if that made them feel more comfortable. Approximately 40 school professionals were offered a chance to be interviewed. Potential participants at the school included school social workers, teachers, principals, para-professionals, and behavioral intervention specialists.

Protection of Human Subjects

An informed-consent form (see Appendix B) was created to explain the purpose of the study, why the participants were selected, the procedure of the study, risks or benefits associated with the study, issues of confidentiality and that participation was completely voluntary. In order for a participant to agree to participate in the study, he or she was required to sign the consent form. The researcher provided a copy of the signed consent form for the participant's records. The researcher also encouraged the participants to ask questions before and after the interviews to gain further understanding about the research study. The researcher reminded the participants that the study was voluntary and the participants were allowed to withdraw their participation at any time. Participants were informed that their identities and statements would be kept confidential. A number identifies each participant and no names were used in the finished written product. To ensure confidentiality, all information identifying the participants was kept on a password-protected computer. All data was examined and transcribed by the researcher, while the researcher's committee chair reviewed the information.

Data Collection Instrument and Process

The data collection instrument in this study was a semi-structured interview—refer to Appendix A for interview questions. The researcher asked a series of questions

concerning the professionals' perceptions of students' barriers to learning and the effects trauma has on students in the school. A few questions asked: what age group are you working with? Do you see specific barriers to learning in this age group? What have you seen as the biggest barriers to a child's learning? How does your school approach children's educational barriers differently from other schools? The interviews were conducted for no more than a 60-minute period of time at the school in a private room. The interviews were a one-time interview, and they were all face-to-face interviews. Participants were given the opportunity to obtain a copy of the findings of this study and were invited to attend the formal presentation of the findings from this study.

Data Analysis Plan

The transcribed interview data was analyzed using the grounded theory approach (Strauss & Corbin, 1998). The transcriptions from the interviews were read line-by-line, through an inductive approach, to establish themes from the data. The researcher identified and made note of words and phrases that were repeated in all the interviews. Various categories were identified by grouping words and phrases together, and from these categories the major themes were established.

Findings

This qualitative study sought to gain an in-depth understanding of school professionals' perspectives on how trauma impacts students' academic abilities and how schools can better assist students in the future. Of these, four professionals responded and participated in qualitative interviews, all of which included female teachers. Participants had been practicing as schoolteachers between one and nine years, respectively. At the time of the interviews, all participants currently taught in a classroom setting at the school.

In order to provide the reader with an in-depth understanding of the data, a brief description of each participant's experience will be given as well as the participants' perspectives of what the biggest educational barriers are for their specific age group. After all individual descriptions are provided, the themes from the interviews will be discussed in regards to the themes that have been used to code the data. These themes include developmental barriers and strategies the school uses. Themes were defined by at least two participants identifying the same idea. Quotations were chosen that best represented the various themes and will be italicized.

School Professionals' Background

Participant 1.

Participant one was a first grade teacher who has taught at the school for three years. Prior to her time at this particular school, she was also a first grade teacher at another elementary school for one year. She also has experience subbing in schools in an inner-city school district.

Participant one discussed barriers that she sees in her students' education. In the age group she is working with

“a lot of things are developmental...they have the skills to be reading, for example, but can't put them all together.” She also reported that *“they have a really hard time with abstract things... curriculum is so far over their heads they have a hard time with it.”*

The main barrier that participant one sees in her students has to do with their developmental abilities, and she identifies that in the school as a whole, the barriers are difficult home lives and also the developmental piece.

Participant one discussed a specific student who had quite a bit of trauma at home and drew her a picture of him/herself committing suicide. She also described a student situation where she was aware of police raids at home and drug use in the home.

“[Student] would hear voices and things like that, and was so far behind grade level but had all these things that [the student] wasn't able to deal with. So at this school I have just seen so many of these kids with difficult home lives and it presents itself at school. They don't always choose to do the things they do they just have so much to deal with that it comes out in different ways at school.”

Participant 2.

Participant two was a Kindergarten teacher in the school. She has worked at the school for five months. Participant two identified that prior to working at this school she worked with diverse populations in other schools in the district. Participant two reported that the main barriers in her classroom were delayed development and immaturity. In the

school as a whole, she identified that language and undiagnosed disorders were major barriers for students as well.

Participant 3.

Participant three was a special education teacher in the school who specialized in emotional behavioral disorders. She has worked at the school for two years, and she services Kindergarten through fourth grade. Prior to being at this school, she was subbing in an inner-city school district for a few years.

Participant three did not have comments on specific barriers for a certain age group because she was working with so many different grade levels. She did discuss barriers she saw to students' academics for the student body as a whole. The barriers that she identified were living in poverty and the lack of parental/guardian engagement.

Participant 4.

Participant four was a second grade classroom teacher. She has been at the school for one year, but she has been teaching for a total of nine years. Prior to working at the school, she was in a trauma-informed school in a different inner-city school district for five years and then prior to that she was subbing in schools in the same inner-city school district.

Participant four identified that delayed development and difficult homes lives are the biggest barriers to students' academics in her classroom.

“They come to school and we expect them to memorize math facts and learn reading strategies, but they are wondering am I going to eat, is mom home, lots of things. I have one little boy who has shown that he knows what drugs are and has seen people using them, so their minds aren’t really here like most kids that age.”

Themes

Developmental barriers.

Throughout the research participants reported that one of the main barriers that students face at the school is their delayed development. The developmental barriers affect the students' academics significantly. Participant one recalls a situation with a student:

I think particularly about students I've had. I had one student last year whose mother died when they were four and their mom just had a heart attack and died so the student went to live with their grandma and grandma was not mentally stable so the student was not able to mentally process mother dying at that age, so it presented itself in the classroom. They were very physical aggressive and he was also so far behind grade level. They left first grade knowing no even their whole alphabet and very few sounds and no sight words.

Participant four stated *"Well I think what's hard with this age group is they are not necessarily where most kids are at that age because of situations they have come from."*

Physical/verbal aggression.

One of the main ways that delayed development presents itself at the school is through physical aggression. Participant three reports, *"They may run out of the room or become verbally or physically aggressive. Many of these symptoms can lead to a loss of instructional time."* Participant one also described a student's aggression, *"I see a lot of kids that I have worked with have aggression. I had a kid who tried to choke out another kid and he was really strong when he was in that mode and I could barely pry his hands off that other kid. I have a lot of kids with physical aggression."*

Participant two and four also listed physical and verbal aggression as serious barriers in the classroom when it comes to students' academics. This is an important barrier to understand because it has significant repercussions in the classroom such as, physical safety of peers and teachers as well as loss of educational and instructional time. As participant three mentioned, these aggressive outbursts cut in on classroom learning and instruction.

Hyperactivity/focusing.

The participants also named hyperactivity and the inability to focus as another main developmental barrier in the classrooms. Participant two states, *"Academically, students with trauma may have trouble focusing, may refuse to do work or require a lot of one on one assistance to complete tasks."* Participant three echoes this idea, *"It impacts their ability to focus, pay attention, and stay on task in the classroom."*

Participant one reflects on a student she once had:

"And then this other student I think of just had so much hyperactivity he literally could not sit still for two minutes. And for reading, it's not that he couldn't read, it was that he couldn't sit still long enough to look at the works on the page." Participant four also reflects on her experience in the classroom:

Sometimes it is even physical, they physically cannot sit still, they cannot pay attention, they cannot focus. So we just try different things to help them like put more movement in and do all sorts of things but once again that's something that I have to learn. And then when you have kids who have been through trauma it is disruptive to the class because not every child as been exposed to trauma so there's a lot of stop and start over and redo.

Managing emotions.

When interviewing the participants it came up frequently that students' have a difficult time managing their emotions. This shows up in many different ways.

Participant two reported, *"I have seen trauma effect students ability to manage emotions and behaviors."* While participant three noted that symptoms present themselves through *"aggressive behaviors, running, lack of social skills, crying, worrying, hyperactivity, and inattentiveness. Sometimes students need to see the nurse often as well."*

Participant four discussed how students come into school in the morning as an example of their emotional mismanagement as a developmental barrier:

Just like everything from coming in the morning and being depressed, I mean you would think elementary kids coming into school and being excited but some of our kids do not come in like that, they are crying or upset...they are way up here we just call it riding high when they get here and it is trying to regulate them...there is also one that I am thinking of specifically, so behaviorally he is more like a four or five year old. If things do not go his way or he gets caught at something or at a game where the kids will call him out on something he will cry like a younger kid would and not deal with it like a seven or eight-year-old would. Physically he stands out in the hallway and he is moving around and he looks like a kindergarten or first grader in his ability to control himself. They definitely have a hard time controlling their emotions.

Strategies the School Uses

Participants identified specific strategies that the school implements to help students in their academics. It is these specific strategies that this school implements that

made the researcher choose this school for a case study. There are many unique things the school adopts from other schools in the district that has made them stand out.

Trauma-Informed/Mental Health Trainings.

One area where this school is making strides is in the area of becoming a trauma-informed school. Participant one discussed their use of professional learning communities (PLCs) trainings:

Last year we had the PLCs once a month for 50 minutes. Our grade level social worker would give a presentation on recognizing trauma or learning about different kinds of mental health disorders that kids might have and different strategies on how to deal with that, so we had that last year. This year we unfortunately do not have those PLCs anymore, but for our professional development day we had an afternoon dedicated to mental health issues and trauma and recognizing those kind of things and every now and then after a staff meeting the school social workers present things like that because they are such a big part of our population here.

Participant two also discussed the trainings they receive from within in the school. “*Our school social workers have done several presentations and are moving our building to be trauma-informed and I have had required trainings for mental health.*”

While the staff at the school receive trauma and mental health trainings within the school and district, which they voiced are incredibly helpful, they still feel like there is a lack of understanding for them as teachers. Participant four voiced concern in this area.

We do get a lot of training on trauma and what it looks like and how it affects kids, but I still feel very inadequate. And even in ways that I am not a special

education teacher. Like I can modify the work, but I do not know if I am doing it in the right way. I can make accommodations but I am not 100% sure that I am doing the right thing, so I do not feel like we are trained like we should be if we are going to be working with kids like this I do not know that we are really helping.

School Support Staff.

A large support for students in the school is the non-teaching staff. There are multiple different professionals employed that aide in supporting students and staff. Participant three discussed how this school approaches children's educational barriers differently from other schools in the district. *"At our school we do co-teaching with special education and English language learner teachers. Also the social workers at the school are building a trauma-informed school."* Participant two also touched on the support at the school being something that sets them apart from other schools in the district. *"The support we receive from support staff is swift like the school social workers, speech therapists, and occupational therapists, they are all very quick to get involved and help."*

Participant four spoke in depth about the support she has received from the support staff at the school and how much of an asset that has been for her as a teacher:

We have social workers that are very aware. I mean I can call my grade level social worker and if I do not get her she is still in my room in two minutes asking what is going on and what I need. So the response time is incredible, and I do not know how long they will be able to maintain that. I really have one that really needs help, I mean there are probably others that we do not know about, but there

is one who is in trauma at this moment. So we have that and the assistant principal and the principal are readily available when you call the office and they are right on top of it.

Participant one also spoke about the specialized, one on one aide she has received from support staff:

For one student we had our school social worker who would help out with things, so we wanted to also work with her on her numbers so I would do some activities with her one-on-one...then our school social worker would track her progress once a week since she is more able to do that than I am because I have so much going on it is hard to do all of that.

All the participants spoke very highly of how much support they receive from support staff in the school, and they have found that they are able to focus better on their students' academics.

Incentives.

Another strategy that this school implements to help students is the implementation of incentives. Participant one discussed how she used an incentive with a student and saw great results.

“We might have different incentives for kids especially those who have those aggressive behaviors. I had a student two years ago who something was going on at home and she did not want to come to school and so we have her a little transitional object that she could hold for comfort to help her settle into the school day and that helped a lot.”

Participant two also reported about a specific program that the school uses called CARES buddies. CARES stands for cooperation, attention, responsibility, empathy, and self-control. CARES buddy is a mentoring program. Staff volunteer if they want to be a mentor, and they are matched with a student. The student is usually one with behavior referrals meaning they received tier two or tier three support. They also can be paired with a student who has attention-seeking behaviors. Mentors meet with students once a week for 15-20 minutes for extra positive attention (Personal Communication, March 25, 2016). *“The school social workers have CARES buddies they check in with a couple times a week and they also pull groups for social stories and lessons.”* The incentives look different for different students and some individual interventions can also be incentives for students. All participants also touched on a school pride day where students have the opportunity to earn certificates and be recognized in front of the whole school for good behavior and academics.

Working with Parents/Guardians.

Participant three spoke about the importance of working with parents/guardians. *“Building relationships with parents is important [to] student success....strong collaboration between home, school, and community is very helpful. Students who have parent/guardian support and the support of community members will do better than those who do not have those supports generally.”* Parents/guardians who are not engaged in their student’s education this is something that participants also identified as one of the main barriers to students’ educational.

Participant four also spoke about the struggle she has faced working with parents and guardians.

I have not had really good luck this year with parents. One parent I have tried to work with this year has been very difficult, she just keeps her head down and does not really want to talk about it or hear it or face it maybe. And I do not know what to say because I do not have that issue and I do not know what they have been through or what she is going through as a parent. So it has been difficult...I find that the community is more supportive than the parents.

Participant four did touch on some benefits she has had working with parents.

“Another thing that helped me a ton this year was meeting the parents at conferences. It just gave me a whole different look on the child. It brought me back to the fact that every child comes from parents and a family who care about them no matter how difficult they are.”

Participant one also spoke about reaching parents/guardians.

Most of the parents want the best for their child. So I have noticed that when you linked their behavior to their academics they are much more willing to work with you...A lot of them recognize that their child is struggling, but it is hard for parents to accept that. They want to be able to do it on their own, so you need to build a really good relationship with your families first before you get into that hard stuff.

It is essential for schools to come alongside parents/guardians. As the participants touched on, a relationship is so important in being able to best assist the student because parents/guardians truly want what is best for their child. This is a difficult task and it takes time, but it is proven to be effective once teachers and staff are able to break down those barriers.

Community Outreach/Agencies.

Participant one also discussed how the school reaches out to the families and community. *“We have a family center and I know the family center works hard to send things out and invite families to come to events at the school. I know that is a big piece of reaching the families here.”* The family center is a place where staff are on hand during the school day to provide resources to families to help them in many different areas.

Participant three discussed the need to refer students out for more extensive services. *“Social workers refer to outside agencies if needs are significant and cannot be addressed with just school support.”* Participant three also touched on collaborating with case managers to be able to get the best picture of what they can do at the school. Teachers and staff work hard to communicate with those within the school and agency to best help their students.

Family Innovations.

A special partnership the school has that not many other schools have is a partnership with Family Innovations. This is a mental health agency that is contracted out of the school to work with students who have mental health concerns. The school social workers along with parents make a referral for a student, and the student will go through a diagnostic assessment (DA). Following the DA the student will receive services and supports from a Mental Health Practitioner (MHP) in school as well as in the home. The MHP is able to communicate with the parents/guardians, teachers, social workers, etc. to provide more extensive supports for certain students. This is a service that all students qualify for. The school social workers usually make a referral, and students are set up with Family Innovations. Parents can also go directly to Family Innovations if they would

like their child to receive services, and based on the DA will or will not qualify for services. The services are billed through insurance, and almost all providers are covered. The most common form is through medical assistance (MA).

Participant four spoke about her experience with Family Innovations. *“We have a program, Family Innovations, that come in. It has been my first experience with them and it has been wonderful. That is the most community outreach that I have had to help with the trauma kids.”* Participants all discussed the extra support they have received from Family Innovations as a wonderful resource for each of them as teachers and for a school and families in general.

Discussion

The purpose of this study was to gain further understanding of what schools can do to help children who are impacted by trauma and the barriers in their education. For the purpose of this study, there was a focus on mental health and school professionals who had experience working with children experiencing trauma at an elementary school in the Twin Cities. It was found that the school studied had many strategies like trainings, effective support staff, and reaching out to families and the community. However, there are still areas that can be improved upon.

This study aimed to research a specific school in an inner-city school district to understand how they approach educational barriers students' face who are experiencing trauma. This research is important because it sheds light on the difficult task of becoming a trauma-informed school. What was found in the research was how incredibly important and effective it is to provide a well-rounded education where mental health is at the center to aid in students' education, especially those who are experiencing or have experienced trauma. School teachers who have experience working with students experiencing trauma discussed different strategies, and key ideas were found in how to best reach these students. The passion behind this research links to personal observation of the significance of school support impacting client's lives, both positively and negatively.

Participants in this research identified different strategies in which their school helps overcome the barriers that trauma creates for students' education. There were two themes that were found: developmental barriers, strategies the school uses, and working with parents/guardians and the community. The study identified the following concepts

as important to understand and practice:

- Developmental barriers commonly present themselves in physical/verbal aggression, hyperactivity, and the inability to manage emotions.
- The use of effective support staff such as school social workers, para-professionals, behavioral aides, etc. are essential in helping students.
- Providing mental health and trauma trainings help teachers and staff gain a better understanding of what students are experiencing and how it commonly presents in the classroom.
- Incentives can help students overcome trauma and stay present in the classroom.
- Working with the parents/guardians and the community are key factors in the success of students.

One respondent provided a response that captured the overall spirit of this research as she described her work in assisting students in the classroom:

I think educating children who have experienced trauma has been so hard. It has changed education so much because it impacts the child who have gone through the trauma and it effects the rest of the class the teacher and their ability to stay positive and moving along without burning out. But mostly for the child in trauma, I have seen so many of them stop at a point where they can't read or they don't have the number sense that they need and it scares me what life is going to be like for them without that ability. I just feel like there has to be some formula or something we can do to change.

Limitations

A limitation of this study was the fact that there were limited views in

participants. The researcher was only able to recruit school teachers for the study, while their point of views were important in the research, a more diverse population would have provided the researcher a wider base of information and perspective. The intention of the research was to speak with school social workers, behavioral specialists, administration, and school teachers, but due to time restrictions and availability, the researcher was unable to recruit a diverse population. One way the researcher could have rectified the recruitment problem would have been to ask the principal for assistance in recruitment. There could have been more of an incentive for participation if the principal was encouraging it.

Another limitation in the research was the question formatting. There was a specific question that did not get a good response from the participants. The problem may have been with how the question was formatted. The question was, “what have you seen as the greatest success in reaching children with mental health concerns?” The participants spoke briefly about successes they have seen, but the responses were not what the researcher was intending when asking the question. In the future, the researcher would need to make the interview questions more specific and concrete for participants, and also be able to ask participants to expand on their answers to help probe for a better response.

Strengths

A strength of this study was that the researcher heard the voices of those dealing directly with students who are experiencing trauma. While the population was limited to school teachers, the information they gave was insightful. These are the individuals who are dealing with students every single day, and they have so much experience in working

with students' trauma. This provided the research good insight into what this school deals with, and how students are presenting in this particular school.

Implications for Social Work

Practice.

This research allows an important trauma lens for practicing social workers to understand what is happening in the schools, and how they can be better assisting schools and families. This impacts school social workers greatly, but social workers that are working with elementary and secondary school students in general can gain important information from this research.

From the research, it can be seen that the relationship social work professionals have with the schools is increasingly important. Teachers and support staff look to have open communication with mental health professionals that students are seeing outside of school for better insight into what they can be doing in the classroom. This collaboration is increasing more important, and social work professionals need to know how to be effective in communicating with schools. This also helps the professionals in schools to get a better understanding of what they can be doing in the classroom to facilitate an effective learning environment for their students, especially those who are experiencing trauma. The more the gap between schools and social work professionals can be closed the better school and social work professionals will be able to help students and clients.

Policy.

A major policy that can be affected by this research is the training that school professionals receive regarding mental health and trauma. While the teachers noted that the school social workers provided in house trainings, the teachers still felt like they

knew very little about how to practically help their students who have mental health concerns and/or those who are experiencing trauma. This shows a great need in teachers' fundamental education. When looking at education programs in the Minnesota area schools such as The University of St. Thomas, St. Catherine's University, the University of Minnesota, and the University of Northwestern-St. Paul, there is only one general psychology course required in the core program for undergraduate education. Mental health educational requirements should be increased for those going into educational careers because so many classrooms are affected by students who have mental health concerns. This task should not solely fall on the school social workers, and the participants that were interviewed expressed a desire to be able to learn more about mental health and trauma concerns. This lack of educational training does not stop at education majors though; there are no requirements at the master level in social work either for education in trauma. In the University of St. Thomas and St. Catherine's University school of social work masters program there is no required trauma course. There are electives that students can take in they are interested. Also the Board of Social Work, in Minnesota, does not have any trauma requirements prior to licensure. It is shocking to see the lack of educational requirements for trauma when this is becoming more of a prevalent issue in the social work and education communities.

Recommendations for Future Research

The intent of this research was to gain an understanding of what a specific elementary school in the Twin Cities was doing to help students academically who were experiencing trauma. For future research on this topic, it would be important to research other elementary schools to understand how each school approaches academics and trauma. As this research focused solely on an individual school, it would be important to gain a better understanding of certain districts as well as the Minnesota school system as a whole. This would help understand what could be implemented at a state level to help schools assist students who are experiencing trauma academically.

Another area that could be researched further is the effectiveness of the education teachers are receiving. While not every school is a school with high needs, there are more and more trauma-informed schools and even within those schools teachers are feeling inadequate and unprepared to assist students. There could be interesting information to be found from teachers about what they feel would help them assist students more effectively. This could also branch out to school support staff as well, whether it is education or specific trainings and certifications that they could receive more research would be able to help future and current teachers feel better equipped for their students.

References

- Alexander, K.L., Entwisle, D.R., & Kabbani, N.S. (2001). The dropout process in life course perspective: Early risk factors at home and school. *Teachers College Record, 103*, 760-822.
- Alisic, E., Bus, M., Dulack, W., Pennings, L., & Splinter, J. (2012). Teachers' experiences supporting children after traumatic exposure. *Journal of Traumatic Stress, 25*, 98-101.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: American Psychiatric Publishing.
- Armstrong, M.W. & Holaday, M. (1993). The effects of psychological trauma on children and adolescents. *Journal of Counseling & Development, 72*.
- Baum, N.L. (2005). Building resilience: A school-based intervention for children exposed to ongoing trauma and stress. *Journal of Aggression, Maltreatment, and Trauma, 487-498*.
- Beehler, S., Birman, D., & Campbell, R. (2012). The effectiveness of cultural adjustment and trauma services (CATS): Generating practice-based evidence on a comprehensive, school-based mental health intervention for immigrant youth. *Am J Community Psychology, 50*, 155-168.
- Berliner, L. (2013) What is traumatic stress? *Trauma-Informed Child Welfare Practice, 1-43*.
- Bornstein, D. (2013, November 13). Schools that separate the child from the trauma. Retrieved from http://opinionator.blogs.nytimes.com/2013/11/13/separating-the-child-from-the-trauma-_r=0

Briere, J.N. (1992). *Child abuse trauma: Theory and treatment of the lasting effects*. California: SAGE Publications.

Briere, J.N. & Scott, C. (2015). *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment*. California: SAGE Publications.

Cohen, J.A., Mannarino, A.P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents*. New York: The Guildford Press.

Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M., Cloitre, M., DeRosa, R., Hubbard, R., Kagan, R., Liautaud, J., Mallah, K., Olafson, E., & van der Kolk, B. (2005). Complex trauma in children and adolescents. *Psychiatric Annals* 35(5), 390-398.

Cross, K. (2012). Complex trauma in early childhood. Retrieved from the American Academy of Experts in Traumatic Stress Website:
<http://www.aets.org/index.html>.

Ford, J.D., Grasso, D., Greene, C., Levine, J., Spinazzola, J., & van der Kolk, B. (2013). Clinical significance of a proposed developmental trauma disorder diagnosis: Results of an international survey of clinicians. *Journal of Clinical Psychiatry*, 74(8), 841-849.

Gearity, A.G. (2009). Developmental Repair Model. Retrieved from
<https://washburn.org/wp-content/uploads/2015/07/WCCDevRepair-revised.pdf>

Greene, R.W. (2014). *Lost at school: Why our kids with behavioral challenges are falling through the cracks and how can we help them*. New York, NY: Scribner.

Harris, N.B. (2014, September) How childhood trauma affects health across a lifetime [Video file]. Retrieved from https://www.ted.com/talks/nadine_burke_harris_

how_childhood_trauma_affects_health_across_a_lifetime?language=en.

- Kisiel, C.L., Fehrenbach, T., Torgersen, E., Stolbach, B., McClelland, G., Griffin, G., & Burkman, K. (2014). Constellations of interpersonal trauma and symptoms in child welfare: Implications for a developmental trauma framework. *J Fam Viol*, 1-14.
- Koffman, S., Ray, A., Berg, S., Covington, L., Albarran, N.M., & Vasquez, M. (2009). Impact of a comprehensive whole child intervention and prevention program among youths at risk of gang involvement and other forms of delinquency. *Children & Schools*, 31(4), 239-245.
- National Child Traumatic Stress Network, 2015, <http://www.nctnet.org>.
- Painter, K. & Scannapieco, M. (2013). Child maltreatment: The neurobiological aspects of posttraumatic stress disorder. *Journal of Evidence-Based Social Work*, 10, 276-284.
- Perry, B.D. (2000). Traumatized children: How childhood trauma influences brain development. *Journal of the California Alliance for the Mentally Ill*, 11(1), 48-51.
- Perry, B.D. (2006). Applying principles of neurodevelopment to clinical work with maltreated and traumatized children: The neurosequential model of therapeutics. *Working with traumatized youth in child welfare*, 27-52.
- Perry, B.D. & Azad, I. (1999). Post-traumatic stress disorders in children and adolescents. *Current Opinions in Pediatrics*, 11, 1-11.
- Perry, B.D., Pollard, R.A., Blakeley, T.I., Baker, W.I., & Vigilante, D. (1995). Childhood trauma, the neurobiology of adaptation, and “use-dependent” development of the

brain: How “states” become “traits”. *Infant Mental Health Journal*, 16(4). 272-286.

Pinna, K.L. & Gerwitz, A. (2013) The impact of trauma from early childhood through adolescence: A developmental perspective. *Trauma-Informed Child Welfare Practice*. 1-43.

Porche, M.V., Fortuna, L.R., Lin, J., & Algeria, M. (2011). Childhood trauma and psychiatric disorders as correlates of school dropout in a national sample of young adults. *Child Development*, 82(3), 982-998.

Rogers, A. (2006). Human behavior in the social environment. New York: McGraw-Hill.

Rustin, J. (2012). Infant research and neuroscience at work in psychotherapy. New York: WW Norton & Company. Chapter 4 “The Fear System.” 109-142.

Spinazzola, J., Habib, M., Knoverek, A., Arvidson, J., Nisenbaum, J., Wentworth, R., Hodgdon, H., Pond, A., & Kisiel, C. (2013). The heart of the matter: Complex trauma in child welfare. *Trauma-Informed Child Welfare Practice*. 1-43.

Stein, B.D., Jaycox, L.H., Kataoka, S.H., Wong, M., Tu, W., Elliott, M., & Fink, A. (2003). A mental health intervention for schoolchildren exposed to violence: A randomized controlled trial. *American Medical Association*, 1-18.

Strauss, A. L., & Corbin, J. M. (1998). Basics of qualitative research: Grounded theory procedures and techniques (2nd ed.). Thousand Oaks, CA: Sage.

Teicher, M.H., Anderson, S.L., Polcari, A., Anderson, C.M., Navalta, C.P., & Kim, D.M. (2003). The neurobiological consequences of early stress and childhood maltreatment. *Neuroscience and Biobehavioral Reviews*, 27, 33-44.

Tishelman, A.C., Haney, P., Greenwald O'Brien, J., & Blaustein, M.E. A framework for school-based psychological evaluations: Utilizing a 'trauma lens'. 1-47.

Trauma and Learning Policy Initiative (2016). <http://traumasensitiveschools.org>

Walkley, M., & Cox, T. L. (2013). Building trauma-informed schools and communities. *Children and Schools*, 35(2), 123-126.

Wolpow, R., Johnson, M.M., Hertel, R., & Kincaid, S.O. (2011). *The heart of learning and teaching: Compassion, resiliency, and academic success*.

Washington State Office of Superintendent of Public Instruction (OSPI)
Compassionate Schools.

van der Kolk, B.A. (1994). The body keeps the score: Memory and the evolving psychobiology of posttraumatic stress. *Harvard Review of Psychiatry*, 1(5).

van der Kolk, B.A. (2003) The neurobiology of childhood trauma and abuse. *Child and Adolescent Psychiatric Clinics*, 12, 293-317.

van der Kolk, B.A. (2005). Developmental trauma disorder. *Psychiatric Isabellels*, 35.

APPENDIX A: Qualitative Research Interview Questions

1. How long have you worked at the school?
2. Can you describe your role at the school?
3. What are the demographics of children in the school, and how does diversity play a role at the school?
4. What experience do you have with this population prior to working at the school?
5. What age group are you working with? Do you see specific barriers to learning in this age group?
6. What have you seen as the biggest barriers to a child's learning?
7. How does your school approach children's educational barriers differently from other schools?
8. How have you seen trauma impact children?
9. What physical, emotional, and behavioral symptoms do you see in "difficult" children?
10. How do you partner with parents and the community to help the children?
11. What strategies does this school take to support children who have mental health concerns in school?
12. Do staff get trained to work with mental health concerns children may have? If so, in what ways have you seen these trainings help?
13. What have you seen as the greatest success in reaching children with mental health concerns?
14. How have you seen trauma impact learning or the ability to learn?

APPENDIX B

The Barriers Trauma Presents Academically for Elementary School Students: What Can Schools Do?

INFORMATION AND CONSENT FORM

Introduction:

This study is being conducted by Autumn Terlouw, a graduate student at St. Catherine University and University of St. Thomas under the supervision of Dr. Courtney Wells, a faculty member in the School of Social Work. I am conducting a study regarding how school professionals view trauma as a barrier to students' education and what schools can do to aid in helping students overcome those barriers. You were selected as a possible participant in this research because of your experience working with students affected by trauma. Please read this form and ask questions before you agree to be in the study.

Background Information:

The purpose of this study is to gain further understanding of what schools can do to help children who are impacted by trauma barriers in their education. Approximately 10 people are expected to participate in this research.

Procedures:

If you decide to participate, you will be asked to complete a face-to-face audio taped interview. The interviews will last for 60 minutes.

Risks and Benefits of being in the study:

The study has minimal risks. The risk present in this study is the ability to maintain confidentiality. In doing a case study of an individual elementary school, it makes it easier to identify the school, but there are measures in place to maintain confidentiality. There are no direct benefits to you for participating in this research study.

Confidentiality:

Any information obtained in connection with this research study that can be identified with you will be disclosed only with your permission; your results will be kept confidential. Quotations will be used in the written report or publication, however, no one will be identified or identifiable. The data will be secured in a password-protected computer and only the researcher and faculty advisor will have access to the data. All data will be destroyed by June 1, 2016, and consent forms will be destroyed by May 2019.

Voluntary nature of the study:

Participation in this research study is voluntary. Your decision whether or not to participate will not affect your future relations with St. Catherine University or University of St. Thomas in any way. If you decide to participate, you are free to stop at any time without affecting these relationships. You are free to withdraw from the study after the interview has been completed. You may also call the researcher one week after the interview was completed to remove your information from the present research study.

Contacts and questions:

If you have any questions, please feel free to contact the researcher, Autumn Terlouw at autumn.terlouw@gmail.com. You may ask questions now, or if you have any additional questions later, the faculty advisor, Dr. Courtney Wells (well7613@stthomas.edu) will be happy to answer them. If you have other questions or concerns regarding the study and would like to talk to someone other than the researcher, you may also contact Sarah Muenster-Blakley, Director of the University of St. Thomas Institutional Review Board, at muen0526@stthomas.edu. You may keep a copy of this form for your records.

Statement of Consent:

You are making a decision whether or not to participate. Your signature indicates that you have read this information and your questions have been answered. Even after signing this form, please know that you may withdraw from the study at any time.

I consent to participate in the study, I agree to be auto recorded.

Signature of Participant Date

Signature of Researcher Date

Appendix C

We, at XXXXXXXXXXXX Elementary, are in support of the research case study Autumn Terlouw is conducting to meet the requirements for her MSW at St. Catherine's University and the University of St. Thomas.

We find the content of her research to be important, and we agree to be participants in her research.

We will post flyers as well as send out the flyers via email to recruit staff to participate in Autumn's research interviews. We will provide a space to conduct the interviews as well.

Appendix D

Are you a school professional who works
with kids who struggle academically?

You're invited to participate in a study at Bruce Vento!

We are trying to learn more about what schools can do to
help children who are affected by trauma and struggling
academically.

You may qualify if you:

- 1) Are above the age of 18
- 2) Have direct contact working with kids

For more information, please call Autumn Terlouw
at
319-239-6516 or email at
autumn.terlouw@gmail.com